IN THE CIRCUIT COURT, SIXTH JUDICIAL CIRCUIT, FLORIDA
PROBATE DIVISION

IN RE: The Matter of

File No. 01- -IN-3

EXAMINING COMMITTEE REPORT FOLLOWING PETITION ALLEGING INCAPACITY

NAME AGE DATE OF BIRTH
RESIDENCE
CURRENT LOCATION OF ALLEGED
PRIMARY LANGUAGE OF ALLEGED

PHYSICIANS REPORT

Date, time of day and place interview conducted _____
Parties present during interview _____
If anyone other than AIP answers questions, identify party, question and answer: _____
_____
Length of time spent with alleged _____
Personal history of alleged:

- ☐ Length of time in Pinellas County _____
- ☐ Relatives residing in area _____
- ☐ Relatives out of area _____

A. THE RESULTS OF THE COMPREHENSIVE EXAM ARE AS FOLLOWS:

1. Physical examination
   a. Diagnosis:

_____

b. Prognosis: _____

c. Current treatment, including medications: _____
_____

d. Recommended treatment: _____

e. If physical examination is not completed please explain: _____

2. Mental health examination .
   a. Diagnosis: _____

b. Prognosis: _____

c. Current treatment, including medication: _____

d. Recommended treatment:

Are there treatable sources of the diagnosis?	☐ YES	☐ NO
Is the condition reversible?	☐ YES	☐ NO
Is the condition stabilized?	☐ YES	☐ NO

_____
_____

e. If mental health examination is not completed please explain _____

3. Functional assessment
   a. Findings:

Physical appearance of the ward: _____

Living situation of the alleged incapacitated person:

☐ Alleged lives in
☐ home/apt independently ☐ assisted living facility ☐ nursing home
☐ home/apt with live in assistance ☐ other _____

If alleged is living in own home:

☐ Condition of residence_____
☐ Are phone, heat and air conditioning in working order? ☐ YES ☐ NO
☐ Is there adequate and appropriate food in the refrigerator? ☐ YES ☐ NO
☐ Are the kitchen appliances in working order? ☐ YES ☐ NO
☐ **Does the alleged receive in home service i.e.: meals on wheels, home health aids?**
☐ YES ☐ NO
If so what_____
☐ Does the alleged have supportive devices i.e. glasses, hearing aides, walker, wheelchair?
☐ YES ☐ NO
If so what_____
☐ Are the basic health and safety needs of the alleged being met in the home?
☐ YES ☐ NO explain_____
_____
☐ Is the current placement appropriate?
☐ YES ☐ NO explain_____
_____
☐ Is the level of assistance currently being provided sufficient?
☐ YES ☐ NO explain_____
_____
☐ Other concerns and recommendations: _____
☐ **ALF/ Nursing home placement is appropriate?**
☐ YES ☐ NO explain_____
_____

The alleged is capable of performing which of the following activities of daily living (ADL's) and independent activities of daily living (IADL's) without assistance?

☐ Bathing
☐ Dressing
☐ Toileting
☐ Feeding self
☐ **Shopping alone for groceries and clothing**
☐ Preparing own meals
☐ Using the telephone
☐ **Maintain the residence** including housework, laundry and cleaning
☐ Maintain personal hygiene
☐ **Pay bills and maintain checkbook**
☐ Handle cash
☐ **Travel alone** on public transportation
☐ Initiate doctor appointments and follow through with visits

☐ Medication management
☐ Can fill prescriptions as needed
☐ Knows names of medications and purpose
☐ Can accurately self medicate?
☐ Responds appropriately to emergency situations i.e. can dial 911
☐ Is aware of and responds appropriately to personal and in home safety issues
☐ If assistance is necessary to perform the above activities is the appropriate level of assistance being provided?

☐ YES ☐ NO explain _____

Recommendations _____

_____

Cognitive assessment

☐ Tests performed
- ☐ **Folstein** Mini Mental Health Status Exam

☐ Other _____

☐ Memory _____
- ☐ Short term _____
- ☐ Remote _____

☐ Orientation to time, place person _____

☐ Confusion _____

☐ Insight and judgment _____

☐ Likelihood of being exploited _____

☐ **Are there physical impairments**, which might contribute to cognitive deficits?
- ☐ YES
  - ☐ Impaired hearing
  - ☐ Impaired vision
  - ☐ Impaired ability to communicate
  - ☐ Bedridden
- ☐ NO

☐ Decision making ability
- ☐ Simple _____
- ☐ Complex _____

☐ Communication skills
- ☐ Verbal _____
- ☐ Written _____

☐ Comprehension _____

☐ Knowledge of financial affairs
- ☐ **Name and location of** bank(s) _____
- ☐ Nature and amount of assets _____
- ☐ Source and amount of income _____

b. Recommendations to improve the functional capacity of the alleged

_____

_____

_____

B. Was there consultation with the family physician as required by F.S. 744.331 (3)(a)?

☐ YES
☐ NO

If no please explain _____

C. Were prior clinical history and treatment records used?

☐ YES
☐ NO

If yes, please identify _____

D. Were prior psychological/social records or reports used?

☐ YES
☐ NO

If yes, please identify _____

E. Other parties interviewed and their relationship to the alleged _____

_____

G. Factual evaluation of the individual's ability to exercise each of the following civil rights:

1. MARRY
   a. Should right be removed? ☐ YES ☐ NO
   b. Describe the nature and extent of incapacity_____
   c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is_____

2. VOTE
   a. Should right be removed? ☐ YES ☐ NO
   b. Describe the nature and extent of incapacity_____
   c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is_____

3. HAVE A DRIVER'S LICENSE
   a. Should the right be removed? ☐ YES ☐ NO
   b. Describe the nature and extent of incapacity_____
   c. The factual basis for determining that this person lacks the capacity to exercise the right listed above is_____

4. PERSONALLY APPLY FOR GOVERNMENT BENEFITS
   a. Should the right be removed? ☐ YES ☐ NO
   b. Describe the nature and extent of incapacity_____
   c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is_____

5. TO TRAVEL
   a. Should the right be removed? ☐ YES ☐ NO
   b. Should the right be limited? ☐ Yes
      If yes, how should it be limited?
      ☐ Travel limited to within Pinellas County
      ☐ Travel permitted only with supervision of guardian
      ☐ Other_____
   c. Describe the nature and extent of incapacity_____
   d. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is_____

6. TO SEEK OR RETAIN EMPLOYMENT
   a. Should the right be removed? ☐ YES ☐ NO
   b. Describe the nature and extent of incapacity_____
   c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is_____

7. TO CONTRACT

a. Should the right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is

8. TO SUE AND DEFEND A LAWSUIT

a. Should right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the right listed above is

9. TO MANAGE PROPERTY OR TO MAKE ANY GIFT OR DISPOSITION OF PROPERTY

a. Should right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is

10. TO DETERMINE RESIDENCE

a. Should right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is

11. TO CONSENT TO MEDICAL TREATMENT

a. Should right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is

12. TO MAKE DECISIONS ABOUT SOCIAL ENVIRONMENT OR OTHER SOCIAL ASPECTS OF LIFE

a. Should right be removed? ☐ YES ☐ NO

b. Describe the nature and extent of incapacity

c. The factual basis for determining that this individual lacks the capacity to exercise the above right is

H. Other comments, observations and recommendations not included above:

I. Recommendations for increasing capacity

☐ Based on the nature and extent of the individuals incapacity it is recommended that the individual be re-evaluated by the Court in six months to determine if any rights can be restored at that time.

☐ It is my belief based on my examination of this individual and my review of the records that this individual is incapacitated.
☐ The scope of the guardianship is ☐ Plenary ☐ Limited

☐ It is my belief based on my examination of this individual and my review of the records that this individual is not incapacitated in any respect as defined in Florida Statutes, Chapter 744.

Please attach as addenda narrative reports by Committee member as appropriate.

Under penalties of perjury I declare that I have examined the above individual and have based my findings on that examination and review of all pertinent information.

Done this ____ day of _____, _____

_____
(Signature)
(Please print name and address)

_____
_____
_____

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NAME AGE DATE OF BIRTH
RESIDENCE
CURRENT LOCATION OF ALLEGED
PRIMARY LANGUAGE OF ALLEGED

Other Members of Committee:
☐ Psychologist ☐ Gerontologist ☐ Registered nurse ☐ Nurse practitioner
☐ Licensed social worker ☐ Other _____
Date, time of day and place interview conducted _____
Parties present during interview _____
If anyone other than AIP answers questions, identify party, question and answer: _____

Length of time spent with alleged _____
Personal history of alleged:
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e. If mental health examination is not completed please explain _____

2. Functional assessment
a. Findings:
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  ☐ YES ☐ NO explain _____

Recommendations _____
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Cognitive assessment

☐ Tests performed
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☐ Other_____

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b. Recommendations to improve the functional capacity of the alleged

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B. Was there consultation with the family physician as required by F.S. 744.331 (3)(a)?
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If no please explain_____

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Please attach as addenda narrative reports by Committee member as appropriate.

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Done this ____ day of _____, _____

_____

(Signature)

(Please print name and address)

_____

_____

_____